

Idaho Dept. of Health and Welfare
HIV/AIDS Drug Assistance
IDAGAP Application

ALL APPLICATION INFORMATION MUST BE PROVIDED. IF A QUESTION DOES NOT APPLY, PLEASE WRITE "NA" IN THE SPACE PROVIDED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

Client Identification Information:

ADAP ID: _____

First Name: _____

Last Name: _____

DOB: ____/____/____

SS# ____-____-____

Mailing Address: _____

Number and Street

City, County, Zip Code

Contact Phone: _____ Case Manager Name _____

Programmatic Requirements:

- Applicant income is between 151% - 200% of FPL.
- The applicant does not qualify for Medicaid.
- Applicant has Medicare Part "A", or "A and B", and "D" Coverage.
- Applicant does not qualify for Low Income Subsidies.

Medicare Part D Insurance Plan Information: A current photocopy of both sides of your Medicare Part D card MUST be submitted with this application.

Insurance Documentation -- Annual Policy Deductible Amount: \$ _____

Insurance Documentation -- Monthly Premium Amount: \$ _____

Pharmacy Information:

Pharmacy Name: _____ PH# _____

Address: _____ FAX# _____

Number and Street

City, County, Zip

Contact: _____

Client Sig. _____ C.M. _____